

Child's Name: _____

Child's Birthday: ____/____/____

Address: _____

City: _____ Zip: _____

Home Phone Number: (____) ____ - ____

Other Phone # (____) ____ - ____

Mother: _____

Place of Work: _____

Work Address: _____

Wk Phone: (____) ____ - ____ 2nd Phone (____) ____ - ____

E-Mail Address _____

Father: _____

Place of Work: _____

Work Address: _____

Wk Phone: (____) ____ - ____ 2nd Phone (____) ____ - ____

E-Mail Address _____

Siblings:

Name: _____ Birthday: ____/____/____

Name: _____ Birthday: ____/____/____

Name: _____ Birthday: ____/____/____

Physician or Dentist to be called in case of an emergency

	Physician	Dentist
Your child's Medical #		
Phone #		
Address		

Emergency Contacts Information

Name	Relationship	Phone #s

Note: Your child may be picked up ONLY with a written notice from you with each change.

Allergies: _____

Special Health Needs: _____

Notes: _____

Parent(s)\Guardian Signature:

_____ **Date:** ____ / ____ / ____
_____ **Date:** ____ / ____ / ____

WE LOOK FORWARD TO WORKING WITH YOU AND YOUR CHILD!